Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA, TEXAS 77504

Carrier's Austin Representative Box

Box # 19

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Date Received

August 19, 2005

MFDR Tracking Number

M4-05-B563-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Request for Reconsideration letter: "According to TWCC Rule 134.401, the insurance is required make reimbursement at 75% of audited charges for billed charges that reach the stop-loss threshold of $40,000.00. The TWCC rule 134.401 (c)(6) defines 'audited charges' as Total Charges – Deducted Charges. TWCC Rule 134.401 (c)(6) also states that the only charges for which a Carrier is allowed to deduct are: (1) personal items, (2) services which are not documented as rendered during the admission (if an on-site audit is conducted) and (3) items and services which are not related to the compensable injury. The TWCC States in Question Resolution Log 01-03 that 'the carrier should not confuse the carve-out items indentified in section (c)(4) as items that can be deducted in an audit or paid separately.' Further, the TWCC also provides that 'reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement amount of 75% times the total charges.' Therefore, our facility requests immediate and proper reimbursement of 75% of audited charges pursuant to Texas Administrative code Section 134.401 (c)(6)."

Requestor's Supplemental Position Summary Dated November 3, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment…"

Amount in Dispute: $99,148.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 7, 2005: "Requestor billed a total of $164,041.20. The Requestor asserts it is entitled to reimbursement in the amount of $123,030.90, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

Response Submitted by: Flahive, Ogden & Latson

Respondent's Supplemental Position Summary Dated September 9, 2011: "…Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 5, 2004 through October 8, 2004	Inpatient Hospital Services	$99,148.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. 28 Texas Administrative Code §134.600, 29 *Texas Register* 2360, effective March 14, 2004, requires preauthorization for specific treatments and services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F – Fee Guideline MAR reduction $15,016.10
- F – Fee Guideline MAR reduction $2,365.88
- G – Unbundling $0.00
- U – Unnecessary Treatment (without peer review) $1,431.63
- U – Unnecessary Treatment (without peer review) $10,350.00
- U – Unnecessary Treatment (without peer review) $172.50
- U – Unnecessary Treatment (without peer review) $18,330.00
- U – Unnecessary Treatment (without peer review) $2,025.00
- U – Unnecessary Treatment (without peer review) $2,156.25
- U – Unnecessary Treatment (without peer review) $2,242.50
- U – Unnecessary Treatment (without peer review) $42.69
- U – Unnecessary Treatment (without peer review) $7,762.50
- U – Unnecessary Treatment (without peer review) $787.50
- Bill Notes – Globals: incentive spirometrys, incentive spirometers, gowns, surgi kits, drapes, gloves, burr cutting tip, needles, jackson spinal fram patient kits, covers, towels, blades, electrodes, tip cleaners, cords bipolar, mayo cover, syringes, grounding pad, stapler, yankauer suctions, preop time, oximetrys, iv extension sets, slippers, iv start packs, tubing, anes equip, bair warmer, suction cannisters, breathing circuit, monitors, cradle slotted head positioner, upper blanket, opti guard eye proctector, head light, light source, drill, mask, pillows, admission kit, containers, drawing fees, 3 cup plastic medicine, soap dials, and patient bag.
- Reduced according to the usual and customary rates obtained my Mednet.
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $0.00
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $1,431.63
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $10,350.00
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $172.50
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- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $2,365.88
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $2,419.75
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $20,582.10
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $42.69
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $7,762.50
- 24–Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $787.50
- 45–Charges exceed your contractual/legislated fee arrangement
- 97–Payment is included in the allowance for another service/procedure. $0.00
- Bill Notes: Additional allowance has been recommended for the implant invoice 'screw multi' for quantity of 4. We did not have the implant invoice for the implant listed 'connector 7 cross'. Rita Morales with the hospital is still trying to get the invoice for the 'connector 7 cross implant.
- Reduced according to the usual and customary rates obtained by Mednet.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Does the submitted documentation support a contractual agreement exists in this dispute?
3. Did the respondent provide sufficient explanation for denial of the disputed services?
4. Did the audited charges exceed $40,000.00?
5. Did the admission in dispute involve unusually extensive services?
6. Did the admission in dispute involve unusually costly services?
7. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The documentation filed by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon "U – Unnecessary Treatment (without peer review)".

28 Texas Administrative Code §134.600(h)(1) states "The non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions including the principal procedure(s) and the length of stay."

On September 24, 2004, the requestor obtained preauthorization approval for a three day inpatient hospital stay for spinal surgery.

28 Texas Administrative Code §133.301(a) states, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title…"

Since the requestor obtained preauthorization prior to rendering the treatment in accordance with 28 Texas Administrative Code §134.600, a medical necessity issue does not exist in this dispute.

2. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan". The "Network Reduction" amount on the submitted explanation of benefits denotes a discount was taken; however, a copy of a contractual agreement was not submitted to support the reduction. Therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.
3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $164,041.20. The division concludes that the total audited charges exceed $40,000.
4. The requestor in its original position statement asserts that "According to TWCC Rule 134.401, the insurance is required make reimbursement at 75% of audited charges for billed charges that reach the stop-loss threshold of $40,000.00." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons: first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure

fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

> "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the comparison surgeries. Therefore, the requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly when compared to the hospital's resources used in other types of surgeries.

6. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was three days. The surgical per diem rate of $1,118 multiplied by the length of stay of three days results in an allowable amount of $3,354.00.
   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $85,948.00.
   - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Accell Connexus 5cc	1	$650.00	$715.00
BAK Vista 17 x 24 mm	1	$4,155.00	$4,570.50
BAK Vista 19 x 24 mm	1	$4,155.00	$4,570.50
Graft Chamber I/C 10cc GDS010	1	$836.00	$919.60
X-Connector 45mm Blackstone	1	$1,445.00	$1,589.50
Screw Multi 6.0x45	4	$1,265.00/each	$5,566.00
Connector 7 Cross	2	No support for cost/ invoice	$0.00
Screw Set	6	$180.00/each	$1,188.00
Rod 5.5 x 65mm	2	$325.00/each	$715.00

TOTAL DUE	20		$19,834.10

The division concludes that the total allowable for this admission is $23,188.10. The respondent issued payment in the amount of $23,882.10. Based upon the documentation submitted no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/14/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		12/14/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.